Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DALLAS COUNTY HOSPITAL
PO BOX 660599
DALLAS TX 75266-0599

Respondent Name
SERVICE LLOYDS INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-11-1026-01

MFDR Date Received
November 19, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CLAIM DENIED FOR TIMELY FILING"

Amount in Dispute: $118.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As this was an incomplete bill since no information was supplied in Box 14, the bill was returned and the provider had the option to submit a complete bill as a new bill within 95 days of the date of service. . . . Since the provider did not submit a complete bill within 95 days of service, reimbursement was correctly denied."

Response Submitted by: Harris & Harris, 5900 Southwest Parkway, Building 2, Suite 100, Austin, Texas 78735

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 20, 2010	Outpatient Hospital Services	$118.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing and processing.
3. 28 Texas Administrative Code §133.10 sets out the requirements for billing forms and formats.
4. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
5. 28 Texas Administrative Code §133.200 sets out procedures for insurance carriers upon receipt of medical bills.
6. *Texas Clean Claim and Electronic Medical Billing and Payment Companion Guides* (Version 2.0) sets out the Division instructions related to submission of required billing forms.
7. Texas Labor Code §408.027 sets out provisions regarding payment of health care providers.

8. The services in dispute were reduced/denied by the insurance carrier with the following reason codes:
   - 29 – Time Limit for Filing Claim/Bill has Expired
   - RM2 – Time limit for filing claim has expired

Issues

1. Is Box 14 a required element of a paper medical bill submitted on medical billing form UB-04?
2. Did the insurance carrier properly return an incomplete bill submitted by the health care provider?
3. Did the requestor forfeit the right to reimbursement due to untimely submission of the medical bill?

Findings

1. Documentation was submitted to support that the insurance carrier returned a medical bill for the disputed services to the health care provider with the notation "Box 14 missing (REQUIRED!)." 28 Texas Administrative Code §133.2(2) defines a complete medical bill as "A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats)." 28 Texas Administrative Code §133.10(d) requires that "All information submitted on required billing forms must be legible and completed in accordance with Division instructions." The requestor has submitted a sample page from Draft Version 2.01 of the *Texas Clean Claim and Electronic Medical Billing and Payment Companion Guides* to support the requestor's position that Box 14 is not required for outpatient services; however, the Division notes that Draft Version 2.01 of the guide was never adopted and was not in effect for the disputed dates of service. The Division instructions applicable to the disputed services are found in Version 2.0 of the Division's *Texas Clean Claim and Electronic Medical Billing and Payment Companion Guides*, which states that:

   > Usage designators identify when an element is Required (R), Situational (S), Optional (O), or Not Used (N). Current instructions align usage designators with the national standard electronic format usage designators. Previous usage designator Mandatory (M) is the equivalent of the current usage designator Required (R), which indicates that an element must be submitted on the paper billing form for the bill to be considered complete.

   According to the applicable Division instructions, the usage designator for Box 14 of the UB-04 form used for billing the services in dispute is "R"—the element is required. Accordingly, the Division concludes that Box 14 is a required element that must be submitted on the paper billing form for the bill to be considered complete.

2. 28 Texas Administrative Code §133.200 states, in pertinent part, that "(a) Upon receipt of medical bills submitted in accordance with §133.10(a)(1) and (2) of this chapter (relating to Required Medical Forms/Formats), an insurance carrier shall evaluate each medical bill for completeness as defined in §133.2 of this chapter (relating to Definitions) . . . (2) Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier shall: . . . (B) return the bill to the sender, in accordance with subsection (c) of this section . . . (b) An insurance carrier shall not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier shall include a document identifying the reason(s) for returning the bill. The reason(s) related to the procedure or modifier code(s) shall identify the reason(s) by line item. (c) The proper return of an incomplete medical bill in accordance with this section fulfills the insurance carrier's obligations with regard to the incomplete bill." Review of the submitted documentation finds that the requestor's initial bill submission was incomplete. The Division concludes that the insurance carrier has met the requirements of §133.20(c) concerning the proper return of an incomplete bill.

3. 28 Texas Administrative Code §133.20(g) provides that "Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier." §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." No documentation was found to support that the health care provider submitted a complete bill by the 95th day after the date the services were provided. Consequently, the Division concludes that, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	November 1, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.